Facility Program Statement
Executive Summary

URS Bovis Lend Lease
Joint Venture

EXECUTIVE SUMMARY

The California Prison Health Care Receivership Corporation (CPR) was established to assume the management of the California prison medical system and raise the level of health care up to constitutional standards. A significant portion of the total effort to achieve constitutional standards of health care will be the construction of health care facilities to serve the physically ill, the frail, and those suffering from a mental illness (all of whom also qualify for protection under the Americans with Disabilities Act (ADA). The number of needed beds, approximately 10,000 in total, and their distribution between physical and mental illness and male and female patients, was determined only after careful analysis.

In order to establish one, cost effective integrated clinical delivery system, the Receiver assembled a team of experienced correctional and clinical professionals from the Receiver's staff, the California Department of Corrections and Rehabilitation, the Department of Mental Health, referred to in this Facility Program Statement (FPS) as the "Core Planning Team." He also retained, through a formal competitive bidding process, a major program management team (a joint venture between URS and Bovis Lend Lease (URS/BLL)) to ensure the project was properly planned, designed, constructed, and occupied in as expeditiously and fiscally responsible a manner as possible. URS/BLL, in turn, has hired planners, architects, engineers, and support personnel necessary to move the project forward.

Status of Facility Program Statement

Architectural design begins with a research and decision – making process which is referred to as FPS. This FPS is based on a recognized need for the facility and it defines the requirements of the facility in light of those needs.

In the case of the facilities required, very specific population data and facility needs were called out in two reports which carefully examined California prison health care. The first of these reports was "Mental Health Bed Need Study – Based on Spring 2007 Population Projections." This Report was issued in July 2007 by Navigant Consulting. The second report was "Chronic and Long-Term Care in California Prisons: Needs Assessment – Final Report" issued in August 2007 by Abt Associates.

While both of these documents chronicled the need for health care facilities, the reports addressed the population requirements only and did not define the facility design requirements necessary for addressing these populations. The FPS is the document which, in narrative form, defines the facility requirements which are necessary to provide appropriate services for the current and projected populations.

The FPS is the necessary first step of the design process because it:

- Provides for all of the stakeholders to define the scope of the project
- Allows for the project team to gather and analyze data relevant to the design
- Avoids the need for costly redesign once the architectural design process begins

The FPS is built upon a number of steps, two of which, the Options Report (April 9, 2008) available on the CPR website (www.cprinc.org) and the Operational Guidelines Report (June 26, 2008), have already been published, submitted to the Receiver, and made public. The objectives of the efforts prior and present has been to clarify and present the views of the Core Planning Team and the Receiver concerning how a prison health care facility should appear and be operated. The FPS is a compilation of these views, attitudes, data, and operational characteristics which will be used by the Integrated Project Delivery (IPD) teams to create design solutions for these proposed facilities.

The FPS Second Draft was distributed in August, 2008 to the IPD teams so that they could commence with their familiarization of the program, facility design needs, its scope, and critical planning/design principles. Since that time, there have been a series of "drill down" sessions, workshops, and review sessions between the IPD teams and members of the Core Planning Team and URS/BLL planning team. The primary objectives of these review sessions were to provide a forum for transferring information concerning all aspects of the FPS to the IPD teams, prior to their commencement of design studies.

The IPD teams were encouraged to critique and challenge all aspects of the FPS Second Draft and to offer their own ideas and perspectives to the programming content of the FPS. Following this intensive debriefing of the FPS Second Draft to the IPD teams, a series of preliminary design workshops were scheduled where the IPD teams presented preliminary and conceptual ideas about housing forms, building relationships, key functional adjacencies, building massing options, and overall site master planning. Members of the Core Planning Team and URS/BLL participated actively in these design workshops and provided input as appropriate to help guide the direction and priorities of the IPD teams.

This FPS Third Draft represents the most detailed articulation of the effort to date, and has been frequently updated to reflect agreed upon changes to earlier drafts. This FPS Third Draft will be further modified and refined as the planning process continues.

As a result of the research and analysis completed and documented in the Options Report, the FPS provides clear direction to the design teams regarding the scope and intent of all of the services to be provided in the proposed California Health Care Facilities (CHCF). For each of the services, the FPS provides the following:

- Description of the Services – Principles of the service are explained in this section to provide a context of how the service is organized and managed.

- Operational Assumptions – This section provides preliminary protocols and operational guidelines which influence the planning of the space and the functional adjacency requirements.

- Planning and Design Criteria – Preliminary criteria are provided which establish broad parameters regarding the organization and spatial relationship of the functions to be addressed within the space.

- Space Listings – Detailed space lists are provided. These space lists are consistent with the proposed functions and identify the number of spaces required for each function, the square footage requirement for each, and any special features required.

- Special Considerations – This section provides preliminary information regarding special, technical requirements which must be incorporated within each space. Examples of these types of considerations are mechanical, electrical, plumbing, and low voltage systems, which are necessary in correctional health care environments.

Core Principles

The Core Principles guiding the project were first developed and reported in the Options Report. These values are as follows:

- Program design that does not exceed constitutional minimum requirements agreed to by the State of California and plaintiffs' counsel for the *Plata, Coleman, and Perez* class action cases
- Compliance with the Americans with Disability Act (ADA) and Armstrong requirements
- Secure perimeter
- Management of patients by direct supervision
- Minimal physical barriers between patients and staff
- Shared medical and mental health treatment resources
- Housing unit sizes at a manageable level
- Natural light
- Scale, material, and color appropriate for the health care mission
- Appropriate treatment atmosphere
- A single women's health facility, although within the same secure perimeter, separate and gender-responsive

The Core Planning Team and the planning consultants have taken the Core Principles and the Operating Principles and have developed them into the detail represented in the FPS. The FPS begins with descriptions of the various housing categories that will be found in the CHCFs. Beginning with housing is appropriate, because housing – what it looks like and how it's managed – will be the focal point and will drive the management philosophy of these new facilities. Interestingly and fortunately, both the Abt and Navigant reports found that the great majority of needed health care beds were for the least debilitated patients. This finding allows far greater flexibility of design with considerable cost savings than would be the case if a higher percentage of patients had higher acuity health care needs.

Medical Care Beds

Of the medical beds, roughly 70 percent are necessary for patients described as Specialized General Population (Specialized GP). These patients require assistance with activities of daily living due to physical impairment, chronic illness, general frailty, or other complex medical management. They will be housed in 64-bed housing units, primarily in 4-bed cubicles, grouped to form a housing cluster. Typically, six or more housing clusters are supported by a Treatment Mall, which provides programming and outpatient care for the Specialized GP. Mental health patients will reside in similar housing units.

Above Specialized GP, the next level of care refers to Low Acuity. Low Acuity patients are those needing more assistance with activities of daily living and who may be on IV antibiotics, undergoing a wound care regimen, or in need of more intensive nursing care. The Abt Report described these patients as “assisted living” patients.

To ensure their medical needs can be met, the Low Acuity operational model is based on two 24-bed pods that form a 48-bed housing unit. The housing units are grouped around a programming and medical support area to form a cluster. The 24-bed pods have both single patient rooms and cubicles for two to four patients. These patients will receive some services in the Treatment Mall, but considerably more time will be spent in the housing and cluster area.

The highest level of care provided in the CHCFs is described as High Acuity and most closely resembles a skilled nursing facility (as referenced in the Abt Report). The High Acuity patients require access to nursing care 24-hours a day for assessment, monitoring, and/or complex medical management. The High Acuity patients will be in housing units of 30 beds and may be in a 4-bed cubicle or room, a single patient room, or an isolation room depending upon their medical needs. These beds will be in close proximity to a nurses’ station, and almost all medical and programming support will take place in the housing area.

Mental Health Beds

Similar to the medical housing, a significant percentage of the mental health patients will be housed in facilities that are appropriate for Low Acuity patients. These patients, generally categorized as Enhanced Outpatient Program (EOP) patients, are characterized by symptoms of a serious mental illness that creates difficulty in general population housing and program participation. On the other hand, they are not so ill as to require inpatient housing within a mental health setting.

Housing is based on multiple 64-bed units, divided into 32-bed pods, adjacent to a shared housing cluster support area and access to the Treatment Mall. The housing units include 4-bed cubicles, 2-bed rooms, and single patient rooms. Unlike medical Specialized GP, a nurses’ station is included in each 64-bed unit.

Some EOP residents may exhibit unacceptable behavior and be unable to participate in less restrictive treatment activities. These patients will be housed in an Enhanced Outpatient Program High Custody (EOP-H) living unit. The EOP-H bed mix currently consists of all single-patient rooms; although semi-private rooms are also being

evaluated to enable an EOP-H patient to transition into a more mainstream living arrangement.

Patients with mental illness who are in crisis and in need of immediate stabilization due to marked impairment and/or danger to self or others may be placed in Mental Health Crisis Beds (MHCB). The mission of the MHCB is to provide short-term, intensive treatment in order to stabilize the patients so they can be moved back to their assigned mental health housing area.

The MHCB housing unit is composed of two pods of 14 beds, which together will form a 28-bed housing unit. Patients will be housed in either single-occupancy rooms or in a 4-person occupancy dorm room. In addition to the 28 patient rooms, each unit will include observation rooms, safety rooms, a nurses' station, and clinician work areas. Due to the patients' severe illnesses, all program and therapeutic activities will take place in the housing area.

The next level of care for patients with mental illness is the licensed Intermediate Care Facility (ICF). The ICF consists of 30 single-patient room pods, co-located to form a 60-patient unit. Four units will be grouped to form a cluster. The cluster will provide programming, treatment, and patient support and serves as the community center. The treatment continuum includes an effort to improve socialization by moving the patients from a housing to a cluster environment and even, when possible, to the Treatment Mall.

The ICFs also have a high custody housing option (ICF-H) for those ICF patients who have been unable to adjust to the ICF environment. The ICF-H units provide housing for patients exhibiting the same clinical criteria as others in ICF but who are unable to participate due to a high risk for violence to self or others. ICF-H housing consists of three 30-bed units of single occupancy, lockable rooms.

The highest level of care in the continuum of mental health programs is the Acute Psychiatric Program (APP), a licensed acute psychiatric facility. These patients exhibit symptoms of Acute Major Mental Disorder or an Acute Exacerbation of Chronic Mental Illness. Housing is composed of three 30-bed units and all beds are single-patient, locked rooms. The unit also includes a restraint room and a safety room. The 90 beds of the APP are co-located with the 90 beds of the ICF-H and supported by an extensive cluster support area for programming and treatment. In some rare cases, these patients may be escorted to the Treatment Mall for a programming function.

Patients suffering from dementia or the end stages of a terminal illness will be housed in small facilities dedicated to their respective needs.

This FPS Third Draft proposes a change in order to achieve very significant construction and operational savings, from earlier drafts on how female patients will be accommodated. It is now proposed, in order to achieve very significant construction and operation savings, that a single women's CHCF, on the same grounds as a men's CHCF, be created which will be physically separated and managed independently. The women's CHCF will accommodate all female patient needs, including medical, mental health, dementia, and hospice programs. A single hospice unit will be established for this CPR program, and this unit will serve both male and female patients. It will be designed with secure sight and sound separation between the genders.

This will be one of the two unique CHCFs, with the second unique CHCF now providing services only to male patients, although with a considerably higher number of higher acuity mental health care beds than found in the prototypical facilities. This second CHCF, now programmed to accommodate only male patients, will also provide for its own dementia unit in addition to the full range of medical and mental health resources planned.

The two unique CHCFs will continue to house in excess of 1,700 patients each, while the five prototypical male facilities will provide just over 1,300 beds each.

Other Key CHCF Attributes

The various housing types described above are a critical component of these facilities, but present only a partial picture of the CHCFs. A number of commonalities are found throughout the CHCFs. These include the Interdisciplinary Treatment Teams (IDTT), cluster support areas, the Treatment Mall, direct supervision, a safe environment, and a secure perimeter. The IDTT is composed of representatives from a cross-section of clinical disciplines, correctional custody, and counselors who carry out the direct treatment support and supervision decisions for the patient.

With the exception of the Specialized GP patients who are treated on an outpatient basis, all other residents of the CHCFs will have treatment and program services delivered under the guidance of the IDTT.

Integral to the concept of the IDTT is the concept of direct supervision. Direct supervision involves all staff, particularly custody staff, who are directly interacting with the patient. Staff members do not observe patients from enclosed locations; instead, they move among the patients, directly observing their behavior and making corrections as needed.

Housing, treatment, and programming is available to the patients of the CHCFs in the least restrictive environment that their behavior status and illness permit. In the most acute cases, treatment is provided in the housing areas. For other cases, treatment is provided in the housing cluster support areas. The cluster support areas serve as the patient's community and they are encouraged to access cluster support for treatment, programming, and socialization.

Ideally, patients will be stable enough to walk unescorted to the Treatment Mall. The Treatment Mall and its adjacencies provide treatment, education, recreation, and other program opportunities. The strongest, most stable patients will spend most of their day in the Treatment Mall. It provides an environment that requires the development of personal responsibility, as Treatment Mall activities are structured and monitored.

Many factors are integral to the success of the CHCFs, but none more so than the assurance of personal safety. It is imperative that these facilities provide a safe environment for all – staff and patients. Adhering to the concepts of direct supervision will ensure such an environment. In addition, all CHCF sites will include a secure perimeter to insure the safety of the surrounding communities.

Conclusion

The FPS has been developed over the past 15 months to provide guidance to the IPD teams as they develop the architectural designs. The FPS is structured to allow the new facilities to be operated in a consistent manner wherever the facility is located – while still allowing for the unique configuration and constraints of any site selected.

This FPS Third Draft will continue to be updated and revised, as new information becomes available, and as agreed upon changes are approved by the Core Planning Team. Future drafts of the FPS are anticipated and they will be released when appropriate.

Future drafts of the FPS will include annotation to the design standards and code requirements for each of the sections described herein. In addition, staffing projections for the facilities will be addressed. Staffing information will include operations, administration, clinical organization charts, and a detailed staffing list.

Future drafts of the FPS will include a preliminary Integrated Security Plan. This Integrated Security Plan will become a security description for a specific design concept based on the Core Planning Team's security criteria, operation guidelines, and systems configuration phases.

When the Integrated Security Plain is finalized, it will confirm the security systems design for the project, the designs, and equipment for the security work stations and the direction for hardware, detention products, low voltage systems, and other technology.